

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02989

02991

Reg. Dist. No.

190

1. PLACE OF DEATH a. COUNTY <b>Howard</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <b>Maryland</b> c. COUNTY <b>Howard</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Jessups</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Jessups</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Berger Road</b>				d. STREET ADDRESS <b>Berger Road</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>WILBUR</b> Middle <b>PRESTON</b> Last <b>ALLEN</b>				4. DATE OF DEATH Month <b>March</b> Day <b>11</b> Year <b>19 57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1922</b> <b>March 12, 1922</b>	
9. AGE (In years last birthday) <b>34</b> yrs.		IF UNDER 1 YEAR Months <b>34</b> Days <b>34</b>		IF UNDER 24 HRS. Hours <b>34</b> Min. <b>34</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Patuxent, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Archie M. Allen</b>				14. MOTHER'S MAIDEN NAME <b>Marie Upton</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>219 10 6969</b>		17. INFORMANT <b>Douglas Connell, Jessups, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gun shot wound of head</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>976X</b> (c) <b>776X</b> stating the underlying cause lost. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Self inflicted gun shot wound</b>				INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Self inflicted gun shot wound</b>			
20c. TIME OF INJURY Month, Day, Year <b>5:20 a.m. 3-11-1957</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Jessups Howard Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>George E. Burgtorf</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>George E. Burgtorf</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF <b>April 16-57</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Tranquilizing</b>				22d. LOCATION (City, town, or county) (State) <b>Friendship Airport Md</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Connell</b>				24a. REC'D BY REGISTRAR <b>18 1957</b>			
24b. REGISTRAR'S SIGNATURE <b>Robert L. Connell</b>				24c. REGISTRAR'S SIGNATURE <b>Robert L. Connell</b>			

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

MAR 18 1957

RECEIVED

02990

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Howard County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lisbon</u>				c. LENGTH OF STAY IN 1b <u>5 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>-</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>EDGAR</u> Middle <u>JESSE</u> Last <u>BARNES</u>				4. DATE OF DEATH Month <u>3</u> Day <u>15</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1888 - 5/19</u>		9. AGE (In years last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Lisbon</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Benjamin Franklin Barnes</u>				14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT Address <u>Edgar J. Barnes, Jr. Woodbine, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAL Arrest, cerebral hemorrhage,</u> <u>204.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Thrombosis, Anemia,</u> DUE TO (c) <u>Acute myelogenous Leukemia.</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>57</u> , to <u>15 March</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>15 Jan</u> , 19 <u>57</u> , and that death occurred at <u>8: A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Howard E. Hall</u> M.D.				ADDRESS (Street, city or town, state) <u>Sykesville, Md.</u> DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>Howard E. Hall</u>				<u>Sykesville. Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-17-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>McKendree</u>		22d. LOCATION (City, town, or county) (State) <u>Lisbon, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Gartner</u> ADDRESS <u>Gettersburg, Md.</u>				24a. REC'D BY REGISTRAR <u>DAW 19 57</u>		24b. REGISTRAR'S SIGNATURE <u>Deborah</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. 3

MAR 19 1957

RECEIVED

02991

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Howard County</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> <b>xo</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>River Road</b>				d. STREET ADDRESS <b>River Road</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>E.</b> Last <b>CHRISTOPHER</b>				4. DATE OF DEATH Month <b>3</b> Day <b>17</b> Year <b>1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 11, 1889</b>	
9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>J. Hamilton Jenkins</b>				14. MOTHER'S MAIDEN NAME <b>Ella Huttenberger</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give way or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>William C. Christopher, River Road, Sykesville, Md</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular fibrillation</b> <b>410X</b> DUE TO (b) <b>Mitral Stenosis</b> DUE TO (c) <b>generalized arteriosclerosis</b> [Information from the family physician] PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>10 minutes</b> <b>congenital</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I <del>last</del> saw the deceased alive on <b>March 17</b> , 19 <b>57</b> , and that death occurred at <b>10 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>37 Central Avenue</b> DATE SIGNED ACTUAL SIGNATURE <b>Bertrand R Gau</b> M.D. <b>SYKESVILLE Maryland</b> PHYSICIAN'S NAME (Type) <b>Bertrand R GAU</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-20-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc., 1217 St. Paul Street</b>				24a. REC'D BY REGISTRAR DATE <b>3/19/57</b>		24b. REGISTRAR'S SIGNATURE <b>H. H. Hedrick</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



BUREAU 7.5

MAR 20 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02994

02992

Item 9 FilmG212 3-12-57 et

## CERTIFICATE OF DEATH

Reg. Dist. No.

197

ITEM 4: CALL FROM DIR. ON

1. PLACE OF DEATH a. COUNTY <b>Howard County</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard Co.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>West Friendship</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>West Friendship</b>			
c. LENGTH OF STAY IN 1b <b>15 yrs.</b>				d. STREET ADDRESS <b>Route 144</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Route 144</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>WILLIAM THOMAS</b> Middle <b>DAGNEY</b> Last <b>DAGNEY</b>				4. DATE OF DEATH Month <b>MARCH</b> Day <b>25</b> Year <b>1957</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May. 4. 1868</b>	9. AGE (In years last birthday) <b>88</b> yrs.	IF UNDER 1 YEAR Months <b>8</b> Days <b>8</b> Hours <b>8</b> Min.	IF UNDER 24 HRS. Hours <b>8</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Conductor B. &amp; O. R. R. Retired 25 yrs Delaware</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Delaware</b>		11. BIRTHPLACE (State or foreign country) <b>USA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>William Dagney</b>			
14. MOTHER'S MAIDEN NAME <b>Amelia ?</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>			
16. SOCIAL SECURITY NO. <b>none</b>				17. INFORMANT <b>Miss Mildred Dagney (sister) DAUGHTER</b> <b>West Friendship, Howard County Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAL ARREST, CARDIAL FAILURE,</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis, Arteriosclerotic Heart Dis.</b> DUE TO (c) <b>ANEMIA Dehydration.</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1955 to March 1957</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>1955</b> , 19 <b>March</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>5 March</b> , 19 <b>57</b> , and that death occurred at <b>9:00 P. M.</b> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <b>SYKESVILLE</b> DATE SIGNED <b>5 March 1957</b>			
ACTUAL SIGNATURE <b>Howard E. Hall</b> M.D.				PHYSICIAN'S NAME (Type) <b>SYKESVILLE</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>Mar. 9. 1957</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Carmel</b>				22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>HENRY SANDER &amp; SONS, INC. Baltimore Md.</b>				24a. REC'D BY REGISTRAR <b>DATE 7 1957</b>			
24b. REGISTRAR'S SIGNATURE <b>George Sander</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. 3

MAR 7 1957

RECEIVED



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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02993

## CERTIFICATE OF DEATH

02995

Reg. Dist. No.

191

1. PLACE OF DEATH a. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Ellicott City	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Old Fred. Rd R.F.D. 2		d. STREET ADDRESS Old Fred. Rd. R.F.D.2	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Dellia Plante Demmitt		4. DATE OF DEATH Month Day Year March 14 1957	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 10, 1890
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME ----- Plante		14. MOTHER'S MAIDEN NAME Not Known	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Jos. Demmitt		Address Ellicott City, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 443x DUE TO Hypertensive Cardiac-Vascular Disease. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 9. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 10, 1948, to March 14, 1957, that I last saw the deceased alive on March 13, 1957, and that death occurred at 6:39 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Albert Scagnetti M.D.		ADDRESS (Street, city or town, state) 1729 W Lombard St	
DATE SIGNED A. Scagnetti		DATE SIGNED Balto Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-18-57	
22c. NAME OF CEMETERY OR CREMATORY St. Charles Cem.		22d. LOCATION (City, town, or county) (State) Pikesville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Farley Funeral Home Catonsville Md.		24. RECEIVED BY REGISTRAR DATE MAR 19 1957	
24b. REGISTRAR'S SIGNATURE J. E. Loughran			

BUREAU V. S.

MAR 19 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove cap and papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02994

## CERTIFICATE OF DEATH

Reg. Dist. No.

02996

191

1. PLACE OF DEATH o COUNTY <u>Howard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u> x			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sherwood Trailer Park</u>				d. STREET ADDRESS <u>Sherwood Trailer Park</u>			
3. NAME OF DECEASED (Type or print) First <u>THOMAS</u> Middle <u>WATTS</u> Last <u>HARVEY</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>16</u> Year <u>1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 22, 1892</u>	
9. AGE (In years last birthday) <u>65</u> yrs		IF UNDER 1 YEAR		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Univ. of Md.</u>		11. BIRTHPLACE (State or foreign country) <u>Appomattox Cty., Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Walker Harvey</u>				14. MOTHER'S MAIDEN NAME <u>Katherine Crawley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>229-05-5586</u>		17. INFORMANT Address <u>Box 535, Jessup, Maryland.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>4.0.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary atherosclerosis</u> DUE TO <u>10 yrs.</u> (c) _____ PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchitis</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3.11</u> , 1957, to <u>3.16</u> , 1957, that I last saw the deceased alive on <u>3.15</u> , 1957, and that death occurred at <u>2 P. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>320 Montgomery, Laurel, Md.</u> DATE SIGNED <u>3/16/57</u> ACTUAL SIGNATURE <u>Frank L. Weaver</u> M.D. <u>Medicine examines notified + approved</u> PHYSICIAN'S NAME (Type) <u>FRANK L. WEAVER</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 19, 1957</u>		22c. NAME OF CEMETERY OR CREMATOR <u>New Concord Presby. Ch.</u>		22d. LOCATION (City, town, or county) (State) <u>Sherwill, Virginia.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. CHAMBERS CO., Riverdale, Md.</u> ADDRESS				24a. REC'D BY REGISTRAR <u>19 1957</u>		24b. REGISTRAR'S SIGNATURE <u>J. E. Dougherty</u>	

BUREAU V. S.

MAR 2 1911

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02995

## CERTIFICATE OF DEATH

Reg. Dist. No. 24

1 PLACE OF DEATH a. COUNTY <b>HOWARD</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oxen Hill Md.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clarksville, Md.</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>923 Owens Road</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Karen Elaine Hillsinger</b>		4. DATE OF DEATH Month Day Year <b>March 11, 1957.</b>	
5 SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 4, 1956</b>
9 AGE (In years last birthday) <b>1</b> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Washington D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Raymond H. Hillsinger</b>		14. MOTHER'S MAIDEN NAME <b>Irene Blank</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Raymond H. Hillsinger</b>		Address <b>Oxen Hill, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE CARDIAC FAILURE</b> <b>44</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CONGENITAL HEART DISEASE</b> (c) INTERVAL BETWEEN ONSET AND DEATH <b>5 mins.</b> <b>1 year</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>MONGOLISM</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March</b> , 19 <b>56</b> , to <b>March 11</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>March 7</b> , 19 <b>57</b> , and that death occurred at <b>5:30 A.M.</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <b>Charles S. Whitaker, M.D. Clarksville, Maryland 3/11/57</b>			
ACTUAL SIGNATURE <b>Charles S. Whitaker, M.D.</b>			
PHYSICIAN'S NAME (Type) <b>Charles S. Whitaker, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 13, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>L. Gasch's Sons Hyattsville, Maryland.</b>		24a. REC'D BY REGISTRAR <b>DATE MAR 15 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>Nella Burdette</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



RECEIVED

APR 15 1957

BUREAU OF

02996

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HANWARD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Hanward</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Lavinia</u> Middle <u>HOWES</u> Last <u>HOWES</u>		4. DATE OF DEATH Month <u>3</u> Day <u>5</u> Year <u>1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 31 1873</u>
9. AGE (In years last birthday) <u>83 yrs</u>		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Henry Clay Brown</u>	
14. MOTHER'S MAIDEN NAME <u>Anna Holland</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>m</u>		17. INFORMANT <u>John Bruce Brown</u> Address <u>710 E. 11th St</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u> DUE TO (b) <u>Cerebro Vascular accident</u> DUE TO (c) <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>10 hours</u> <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>generalized arteriosclerosis</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March</u> , 19 <u>55</u> , to <u>March</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>March 6</u> , 19 <u>57</u> , and that death occurred at <u>9:15 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Bertrand R. Gau</u>		ADDRESS (Street, city or town, state) <u>37 Central Ave. Sykesville Md.</u>	
PHYSICIAN'S NAME (Type) <u>Bertrand R. GAU</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>March 7, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. James</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <u>MAR 12 1957</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

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02997

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harward</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harward</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>High Ridge Laurel</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>High Ridge Laurel</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Martin J. Kraeski</u>		4. DATE OF DEATH <u>March 15 1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 11, 1888</u> 68 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Harward Co, Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Martin Kraeski</u>		14. MOTHER'S MAIDEN NAME <u>Christine Farmer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Arthur P. Kraeski Laurel, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12:00</u> to <u>1:55 PM</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>15 March</u> 19 <u>57</u> , and that death occurred at <u>1:55 PM</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED <u>3/18/57</u>	
ACTUAL SIGNATURE <u>Robert C. Wingfield</u> M.D.		PHYSICIAN'S NAME (Type) <u>ROBERT C. WINGFIELD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-19-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St Marys Cem.</u>		22d. LOCATION (C. ty, town, or county) (State) <u>Laurel Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>De Witt Saulsberry Laurel, Md.</u>		24a. REC'D BY REGISTRAR <u>—</u> 24b. REGISTRAR'S SIGNATURE <u>D. H. Redrich</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAR 20 1957

BUREAU V. B.



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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Howard Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Highland Manor Nursing Home</u>				d. STREET ADDRESS <u>618 Wyanoak Avenue</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>ADA FLORENCE McCARTY</u>				4. DATE OF DEATH Month Day Year <u>March 1 19 57</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 18, 1873</u>	
9. AGE (In years last birthday) yrs <u>83</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO <u>?</u>			
17. INFORMANT <u>Mr. Mitchell Gould-5226 Balto. Nat'l Pike</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>1 week</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>2/24</u> , 19 <u>57</u> , to <u>3/1</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2/24</u> , 19 <u>57</u> , and that death occurred at <u>5226 Balto. Nat'l Pike</u> , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Wm. J. Tiekner</u> M.D. <u>5226 Balto. Nat'l Pike</u> <u>3/4/57</u> PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/4/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenmount Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tiekner</u>				24a. REC'D BY REGISTRAR <u>4</u>		24b. REGISTRAR'S SIGNATURE <u>A. J. Sedwick</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. AIR FORCE

RECEIVED

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## CERTIFICATE OF DEATH

Reg. Dist. No.

197

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <u>Maryland</u> c. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marysville</u>				c. LENGTH OF STAY IN 1b <u>life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Elin</u> Last <u>NEILSON</u>				4. DATE OF DEATH Month <u>March</u> Day <u>1</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 28, 1877</u>	9. AGE (In years last birthday) yrs. <u>77</u>	IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>19</u> Min. <u>57</u>		IF UNDER 24 HRS Hours <u>19</u> Min. <u>57</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Marysville</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13. FATHER'S NAME <u>Henry Howard</u>				14. MOTHER'S MAIDEN NAME <u>Louise Morris</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Husband - Charles Nelson</u> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery, arteriosclerotic heart</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>disease, anemia, malnutrition</u> DUE TO (c) <u>Coronary failure</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Sept. 56</u> TO <u>March 57</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug</u> , 19 <u>26</u> , to <u>March</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1 March</u> , 19 <u>57</u> , and that death occurred at <u>11:45 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Howard E. Hall</u> M.D.				DATE SIGNED <u>2 March 57</u>			
PHYSICIAN'S NAME (Type) <u>Howard E. Hall</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>March 3, 57</u>		<u>Westliffe</u>		<u>Marysville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Shively</u> ADDRESS <u>Rockville Md</u>				24a. REC'D BY REGISTRAR DATE <u>2 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Alceste</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. B.

APR 8 1957

RECEIVED

03000

CERTIFICATE OF DEATH

Reg. Dist. No. 195

1. PLACE OF DEATH a. COUNTY <b>Howard</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elicot City</b> c. LENGTH OF STAY IN 1b <b>5 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Shaffer Convalescent Home</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Howard</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>x2 Savage</b> d. STREET ADDRESS <b>1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Joshua</b> Middle <b>R.</b> Last <b>Phelps</b>				4. DATE OF DEATH Month <b>3</b> Day <b>9</b> Year <b>1957</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/28/74 1873</b>		9. AGE (In years last birthday) <b>83</b> yrs	IF UNDER 1 YEAR Months <b>3</b> Days <b>9</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Millworker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Textile</b>		11. BIRTHPLACE (State or foreign country) <b>Savage</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Benjamin Franklin Phelps</b>				14. MOTHER'S MAIDEN NAME <b>Achure Bowms</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Wilbur Williams</b>		Address <b>Savage</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Inoperable Carcinoma Left Tonsil</b> <b>140X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocardial Infarct</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b> <b>1 yr.</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Mar. 1<sup>st</sup> 1956</b> to <b>Mar. 9<sup>th</sup> 1957</b> , that I last saw the deceased alive on <b>Mar. 4<sup>th</sup> 1957</b> , and that death occurred at <b>11:20</b> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Savage, Md.</b> DATE SIGNED <b>Mar. 12 1957</b> ACTUAL SIGNATURE <b>Frank E. Shipley</b> M.D. <b>Savage, Md.</b> PHYSICIAN'S NAME (Type) <b>Frank E. Shipley</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/11/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Savage</b>		22d. LOCATION (City, town, or county) (State) <b>Savage, Howard / Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>He Witt Donaldson</b> ADDRESS <b>313 Talbot Ave</b>				24a. REC'D BY REGISTRAR <b>DATE MAR 12 1957</b>		24b. REGISTRAR'S SIGNATURE <b>J. B. Laughlin</b>	



RECEIVED

MAR 14 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film 621-2-11-57 et

## CERTIFICATE OF DEATH

Reg. Dist. No.

03003  
19

1. PLACE OF DEATH a. COUNTY <b>Howard</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>		c. LENGTH OF STAY IN 1b <b>Ellicott City</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Howard</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b> (Home address)		d. STREET ADDRESS <b>Montgomery Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Shaffers Nursing Home</b>		3. NAME OF DECEASED (Type or print) First <b>EFFIE</b> Middle <b>MAY</b> Last <b>REX</b>		4. DATE OF DEATH Month <b>March</b> Day <b>8</b> Year <b>1957</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 22, 1876</b>		9. AGE (In years last birthday) <b>80</b> yrs.		10. IF UNDER 1 YEAR Months <b>8</b> Days <b>19</b> Hours <b>19</b> Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>Albert Murray</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Clara Arnold, Ellicott City, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>UREMIC ACIDOSIS</b> <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>RENAL ARTERIO SCLEROSIS</b> DUE TO (c) <b>CONGESTIVE HEART FAILURE</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 wks</b> <b>years</b> <b>months</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1-24-</b> 19 <b>56</b> , to <b>3-8-</b> 19 <b>57</b> , that I last saw the deceased alive on <b>3-7-</b> 19 <b>57</b> , and that death occurred at <b>10:30</b> A.M., from the causes and on the date stated above.		ACTUAL SIGNATURE <b>Donald E. Fisher M.D.</b>		ADDRESS (Street, city or town, state) <b>Ellicott City</b>		DATE SIGNED <b>3-9-57</b>		PHYSICIAN'S NAME (Type) <b>DONALD E. FISHER M.D.</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-11-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Johns</b>		22d. LOCATION (City, town, or county) (State) <b>Ellicott City, Md</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higginbotham, Ellicott City, Md</b>		ADDRESS <b>Ellicott City, Md</b>		24a. REC'D BY REGISTRAR <b>DATE</b> <b>11 1957</b>		24b. REGISTRAR'S SIGNATURE <b>J.E. Dougherty</b>													

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please return to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
MAR 11 1957  
BUREAU Y. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 3-22-57 et

## CERTIFICATE OF DEATH

03004 191

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Granite</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Shaffers Nursing Home</b>				d. STREET ADDRESS <b>Granite</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>BRAZIL BROWN SHIFFLETT</b>				4. DATE OF DEATH Month Day Year <b>March 15, 1957 19</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 8, 1872 1871</b>	9. AGE (in years last birthday) yrs. <b>85</b>	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farmer</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Gladys Pack, Granite, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL THROMBOSIS</b> 4 days DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>VIRUS INFLUENZA, DEHYDRATION</b> 5 days DUE TO (c) <b>CONGESTIVE HEART FAILURE (TREATED)</b> 10 days PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>						INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 7, 1957</b> , to <b>March 15, 1957</b> , that I last saw the deceased alive on <b>March 15, 1957</b> , and that death occurred at <b>10 P. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Donald E. Fisher</b>				ADDRESS (Street, city or town, state) <b>Ellicott City, Md</b>		DATE SIGNED <b>3-16-57</b>	
PHYSICIAN'S NAME (Type) <b>DONALD E. FISHER MD</b>				ADDRESS <b>ELLICOTT CITY MD</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 19, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Family lot on farm</b>		22d. LOCATION (City, town, or county) (State) <b>Quince, Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Higinbotham, Funeral Home, Ellicott City, Md.</b>				24a. REC'D BY REGISTRAR <b>DATE 19 1957</b>		24b. REGISTRAR'S SIGNATURE <b>J. E. Lougherang</b>	

W. A. OWEN

1957

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03005  
190

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Howard</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkridge 27</b>				c. LENGTH OF STAY IN 1b <b>27</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2113 Church Ave.</b>				e. STREET ADDRESS <b>2113 Church Ave</b>			
3. NAME OF DECEASED (Type or print) First <b>PINKNEY</b> Middle <b>SIMMS</b> Last <b>Jr.</b>				4. DATE OF DEATH Month <b>March</b> Day <b>30</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 28, 1915</b>	
9. AGE (In years last birthday) <b>42</b> yrs.		10. IF UNDER 1 YEAR Months <b>42</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		11. IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>		12. CITIZEN OF WHAT COUNTRY? <b>Baltimore, Md</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>			
13. FATHER'S NAME <b>Pinkney Simms</b>				14. MOTHER'S MAIDEN NAME <b>Mattie Sewell</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Pinkney Simms, Elkridge, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Epilepsy</b> <b>353.3</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>353.3</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>353.3</b> (b) <b>353.3</b> (c) <b>353.3</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>19</b> o. m. <b>19</b> p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>George E. Burgtorf</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>George E. Burgtorf</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATED ON (City, town, or county) (State)	
<b>Burial</b>		<b>3/30/57</b>		<b>W.H. Calvary Cem</b>		<b>Cedar Hill Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. K. Williams</b>				24a. REC'D BY REGISTRAR <b>322 N. Howard St.</b>		24b. REGISTRAR'S SIGNATURE <b>E. Bird Williams</b>	
				DATE <b>4/4/57</b>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

UREAU V. S.

APR 5 1937

RECEIVED

03004  
**CERTIFICATE OF DEATH**

Reg. Dist. No. 195

1. PLACE OF DEATH a. COUNTY <b>Howard</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>		c. LENGTH OF STAY IN 1b <b>2 weeks</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Shaffer Convalescent Retreat</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Henry</b> Middle <b>Smith</b> Last <b>Smith</b>		4. DATE OF DEATH Month <b>March</b> Day <b>24</b> Year <b>1957</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>unknown</b>
9. AGE (In years last birthday) yrs. <b>81</b>		10. IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>carder</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>cotton mill</b>	
11. BIRTHPLACE (State or foreign country) <b>Howard Co. Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Adolph Henry Smith</b>		14. MOTHER'S MAIDEN NAME <b>Louisa Stoehocker</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>Miss May Mewshaw</b>	
17. INFORMANT <b>Savage, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial Insuff.</b> DUE TO <b>Chronic Myocarditis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>1 yr.</b> (c) <b>Senility</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senility</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Mar. 1st 1957</b> to <b>Mar. 24, 1957</b> , that I last saw the deceased alive on <b>Mar. 23, 1957</b> , and that death occurred at <b>7 A. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Frank E. Shipley</b>		ADDRESS (Street, city or town, state) <b>Savage, Md.</b> DATE SIGNED <b>3/25/57</b>	
PHYSICIAN'S NAME (Type) <b>Frank E. Shipley, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>3-26-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Savage Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Savage, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. H. Carraldan</b>		24a. REC'D BY REGISTRAR <b>1 1957</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>W. H. Carraldan</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03005

## CERTIFICATE OF DEATH

03007

Reg. Dist. No.

191

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <u>Ellicott City</u>		c. LENGTH OF STAY IN 1b <u>2 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Highland Manor Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>S.</u> Last <u>Walbeck</u>		4. DATE OF DEATH Month <u>March</u> Day <u>30</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 3, 1896</u>
9. AGE (In years last birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Balto. City</u>	
11. BIRTHPLACE (State or foreign country) <u>Hartford Co., Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>J. H. Walbeck</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Simms</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>246-03-9654</u>	
17. INFORMANT <u>Mrs. Sadie Delf</u> Address <u>2602 Bustness Dr., York, Pa.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO <u>Arteriosclerotic Cardio-Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>5 yrs.</u> (c)			INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]	
20c. TIME OF INJURY Hour <u>o. 11</u> p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat white <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Mon 4</u> , 19 <u>57</u> , to <u>Mon 28</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Mon 28</u> , 19 <u>57</u> , and that death occurred at <u>1:30</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas D. Herbert</u> M.D.		ADDRESS (Street, city or town, state) <u>46 Church Rd., Ellicott City, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Thomas D. Herbert</u>		DATE SIGNED <u>3/20/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>April 2 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>West Liberty Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>White Hall Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Hartman</u>		24a. REC'D BY REGISTRAR <u>APR 2 1957</u> 24b. REGISTRAR'S SIGNATURE <u>J. E. Laughery</u>	

CERTIFICATE OF DEATH

FILE NO.

Handwritten information in the top section of the form, including fields for name, date, and other details. The text is mostly illegible due to blurring and bleed-through.

BUREAU V. S.

APR 2 1967

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03906

CERTIFICATE OF DEATH

03008

Reg. Dist. No.

191

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3401-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Highland Manor</u>				d. STREET ADDRESS <u>2408 Chelsea Terrace</u>			
3. NAME OF DECEASED (Type or print) First <u>Louis</u> Middle <u>Zemel</u> Last <u>Zemel</u>				4. DATE OF DEATH Month <u>3</u> Day <u>31</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.		10. MONTHS <u>5</u> DAYS <u>10</u> HOURS <u>5</u> MIN.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Book Buyer</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Poland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Admon</u>				14. MOTHER'S MAIDEN NAME <u>Ferna</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Jennie Roman</u> Address <u>5006 Eager St</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cardiac failure</u>							<u>5 min.</u>
422.2 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) <u>Chronic myocardial insufficiency</u>							<u>10 yrs.</u>
DUE TO							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>Mar. 22, 1957</u> to <u>Mar. 30, 1957</u> , that I last saw the deceased alive on <u>March 30, 1957</u> , and that death occurred at <u>1:40 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas A. Herbert</u> M.D.				ADDRESS (Street, city or town, state) <u>46 Church St., Ellicott City, Md.</u>			
DATE SIGNED <u>3/31/57</u>							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>4-1-57</u>		<u>Herring Run</u>		<u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis Inc</u> ADDRESS <u>2100 Euterpe Pl</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>John E. Dougherty</u>	
DATE <u>APR 2</u>							

# CERTIFICATE OF DEATH

BUREAU V. S.

APR 2 1957

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